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BEFORE THE
BOARD OF PODIATRIC MEDICINE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	Case No. 1B-2009-199047
RAMYAR MOUSSAVI, D.P.M.	Case No. 1B-2009-199436
1442 Irvine Boulevard Suite 125 Tustin, California 92780	**A C C U S A T I O N**
Podiatric Certificate No. E 4361, Respondent.	

Complainant alleges:

PARTIES

1. James Rathlesberger ("Complainant") brings this Accusation solely in his official capacity as the Executive Officer of the California Board of Podiatric Medicine ("Board").

2. On or about July 17, 2001, the Board issued Podiatric certificate number E 4361 to Ramyar Moussavi, D.P.M. (Respondent). That certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2013, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following provisions of the California Business and Professions Code ("Code") unless otherwise indicated.

4. Section 2222 of the Code states:

"The California Board of Podiatric Medicine shall enforce and administer this article as to doctors of podiatric medicine. Any acts of unprofessional conduct or other violations proscribed by this chapter are applicable to licensed doctors of podiatric medicine and wherever the Medical Quality Hearing Panel established under Section 11371 of the Government Code is vested with the authority to enforce and carry out this chapter as to licensed physicians and surgeons, the Medical Quality Hearing Panel also possesses that same authority as to licensed doctors of podiatric medicine.

"The California Board of Podiatric Medicine may order the denial of an application or issue a certificate subject to conditions as set forth in Section 2221, or order the revocation, suspension, or other restriction of, or the modification of that penalty, and the reinstatement of any certificate of a doctor of podiatric medicine within its authority as granted by this chapter and in conjunction with the administrative hearing procedures established pursuant to Sections 11371, 11372, 11373, and 11529 of the Government Code. For these purposes, the California Board of Podiatric Medicine shall exercise the powers granted and be governed by the procedures set forth in this chapter."

5. Section 125.3 of the Code, in pertinent part, states:

"(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case."

6. Section 2261 of the Code states:

"Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional

conduct."

7. Section 2472 of the Code, states, in pertinent part:

"(a) The certificate to practice podiatric medicine authorizes the holder to practice podiatric medicine.

"(b) As used in this chapter, "podiatric medicine" means the diagnosis, medical, surgical, mechanical, manipulative, and electrical treatment of the human foot, including the ankle and tendons that insert into the foot and the nonsurgical treatment of the muscles and tendons of the leg governing the functions of the foot.

"(c) No podiatrist shall do any amputation or administer an anesthetic other than local. If an anesthetic other than local is required for any procedure, the anesthetic shall be administered by another health care practitioner licensed under this division, who is authorized to administer the required anesthetic within the scope of his or her practice.

"(d) Surgical treatment of the ankle and tendons at the level of the ankle may be performed by a doctor of podiatric medicine who was certified by the board on an after January 1, 1984.

8. Section 2460.1 of the Code states:

"Protection of the public shall be the highest priority for the California Board of Podiatric Medicine in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount."

9. Section 11519 of the Government Code states:

"(a) The decision shall become effective 30 days after it is delivered or mailed to respondent unless: reconsideration is ordered within that time, or the agency itself orders that the decision shall become effective sooner, or a stay of execution is granted.

"(b) A stay of execution may be included in the decision or if not included

therein may be granted by the agency at any time before the decision becomes effective. The stay of execution provided herein may be accompanied by an express condition that respondent comply with specified terms of probation; provided, however, that the terms of probation shall be just and reasonable in the light of the findings and decision.

"(c) If respondent was required to register with any public officer, a notification of any suspension or revocation shall be sent to the officer after the decision has become effective.

"(d) As used in subdivision (b), specified terms of probation may include an order of restitution. Where restitution is ordered and paid pursuant to the provisions of this subdivision, the amount paid shall be credited to any subsequent judgment in a civil action.

"(e) The person to which the agency action is directed may not be required to comply with a decision unless the person has been served with the decision in the manner provided in Section 11505 or has actual knowledge of the decision.

"(f) A nonparty may not be required to comply with a decision unless the agency has made the decision available for public inspection and copying or the nonparty has actual knowledge of the decision.

"(g) This section does not preclude an agency from taking immediate action to protect the public interest in accordance with Article 13 ([entitled Emergency Decision] commencing with Section 11460.10) of Chapter 4.5."

10. Section 2234 of the Code states, in pertinent part:

"The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5."

11. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

(Bus. & Prof. Code, § 2234, subd. (b))

12. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he committed acts or omissions involving gross negligence in the care and treatment of patients Maria C. and Abel R.[1] The circumstances are as follows:

Patient Maria C.

13. On or about August 6, 2005, 58-year-old Maria C., suffering as a result of bunions[2] on both of her feet, consulted with Larry Ivancich, D.P.M.[3] Dr. Ivancich told her she needed to have surgery on both of her bunions.

14. The records for patient Maria C.'s initial consultation and office visit with Dr. Ivancich on August 4, 2005, show her chief complaint as pain in bunions on both feet. Patient Maria C.'s medical records do not reflect a past medical history, a history or physical taken by Dr. Ivancich or any staff member, no review of systems,[4] no indication of previous conservative care for the bunions, and no pre-operative X-rays.

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[1] The names of the patients are abbreviated to protect their privacy. Their names will be provided to Respondent upon written request for discovery.

[2] A bunion is defined as an enlargement of bone or tissue of the inner portion of the joint at the base of the big toe (the first metatarsophalangeal joint). The enlargement represents additional bone formation, often in combination with a misalignment of the big toe. Bunions are commonly associated with a deviated position of the big toe toward the second toe, and the deviation in the angle between the first and second metatarsal bones of the foot. The small bones found beneath the first metatarsal (which help the flexor tendon bend the big toe downwards) may also become deviated over time as the first metatarsal bone drifts away from its normal position. Arthritis of the big toe joint, diminished and/or altered range of motion, and discomfort with pressure applied to the bump or with motion of the joint, may all accompany bunion development.

[3] Doctor of Podiatric Medicine.

[4] A review of systems in a medical context is defined as a system-by-system review of the body functions begun during the initial interview with the patient and completed during the physical examination, as physical findings prompt further questions. Questions about family or personal history are included in each section. An example of such a review would be questions with regard to:

Past medical history.
Family medical history.
Current medications.

(continued...)

In patient Maria C.'s medical records for this initial visit there are schematic diagrams for a bunionectomy[5] commonly referred to as an Austin/Akin[6] bunionectomy. There is a small

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Previous surgeries.

Skin bruising, discoloration, pruritus, birthmarks, moles, ulcers, decubiti, changes in the hair or nails, sun exposure and protection.

Spontaneous or excessive bleeding, fatigue, enlarged or tender lymph nodes, pallor, history of anemia.

Head and face pain, traumatic injury.

Ears tinnitus, change in hearing, running or discharge from the ears, deafness, dizziness.

Eyes change in vision, pain, inflammation, infections, double vision, scotomata, blurring, tearing.

Mouth and throat dental problems, hoarseness, dysphagia, bleeding gums, sore throat, ulcers or sores in the mouth.

Nose and sinuses discharge, epistaxis, sinus pain, obstruction.

Breasts pain, change in contour or skin color, lumps, discharge from the nipple.

Respiratory tract cough, sputum, change in sputum, night sweats, nocturnal dyspnea, wheezing.

Cardiovascular system chest pain, dyspnea, palpitations, weakness, intolerance of exercise, varicosities, swelling of extremities, known murmur, hypertension, asystole.

Gastrointestinal system nausea, vomiting, diarrhea, constipation, quality of appetite, change in appetite, dysphagia, gas, heartburn, melena, change in bowel habits, use of laxatives or other drugs to alter the function of the gastrointestinal tract.

Urinary tract dysuria, change in color of urine, change in frequency of urination, pain with urgency, incontinence, edema, retention, nocturia.

Genital tract (female) menstrual history, obstetric history, contraceptive use, discharge, pain or discomfort, pruritus, history of venereal disease, sexual history.

Genital tract (male) penile discharge, pain or discomfort, pruritus, skin lesions, hematuria, history of venereal disease, sexual history.

Skeletal system heat; redness; swelling; limitation of function; deformity; crepitation: pain in a joint or an extremity, the neck, or the back, especially with movement.

Nervous system dizziness, tremor, ataxia, difficulty in speaking, change in speech, paresthesia, loss of sensation, seizures, syncope, changes in memory.

Endocrine system tremor, palpitations, intolerance of heat or cold, polyuria, polydipsia, polyphagia, diaphoresis, exophthalmos, goiter.

Psychologic status nervousness, instability, depression, phobia, sexual disturbances, criminal behavior, insomnia, night terrors, mania, memory loss, perseveration, disorientation.

[5] A bunionectomy is a surgical procedure to excise, or remove, a bunion. Some procedures simply address an enlarged bump, some also address a crooked big toe. In order to slow the return of the bunion deformity, most procedures aim to realign the big toe with the bone behind it, i.e., the "first metatarsal." This would also realign the joint surfaces between those two bones. The goal of surgery is to realign the big toe and there are many choices of procedure based upon the patient's individual foot. Various procedures are used for a short first metatarsal, for a long first metatarsal, some for a very unstable foot, and others based on the presence of severe arthritis. Sometimes a screw is placed in the foot to hold a bone in a corrected position, other times a pin, wire or plate is chosen.

[6] An Austin/Akin bunionectomy, also defined as a first metatarsal neck osteotomy, (an osteotomy is a surgical operation whereby a bone is cut to shorten, lengthen, or change its alignment) is known by various names based on the individual who first described the procedure (e.g. Austin, Reverdin-Green, Kalish-Austin). The goal of all these procedures is the same; to remove the bump and realign the joint. The first part of all bunion procedures involves removing

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notation under "musculoskeletal findings" which is illegible. The remainder of the patient's medical record for the initial visit is illegible.

15. Patient Maria C.'s medical records for her initial consultation and office visit with Dr. Ivancich on August 4, 2005, show she signed a pre-operative consent for correction of bilateral bunions.

16. On or about August 10, 2005, patient Maria C. came to the surgical center for the bunion surgery she had scheduled six days earlier with Dr. Ivancich. At the surgery center she was informed for the first time that Dr. Ivancich would not be her surgeon due to a scheduling conflict, and that Respondent would be her surgeon.

17. During Respondent's September 14, 2010, interview with Medical Board Senior Investigator Jaime Sandoval about patient Maria C.'s case, Respondent stated he assumed he spoke with the patient on August 10, 2005, prior to performing her bunion surgery. Respondent could not remember examining the patient, speaking with her, or reviewing her medical records. Respondent does not remember evaluating any pre-operative X-rays.

18. There are no medical records which show that Respondent performed a complete history and physical examination of patient Maria C. prior to performing surgery on the patient on August 10, 2005. There are no medical records which show that Respondent even spoke to Maria C. prior to performing her bunion surgery on August 10, 2005.

19. There are no medical records which show that Respondent either examined previous X-rays of Maria C. or ordered preoperative X-rays for Maria C., or examined X-rays for this patient at any time prior to performing the August 10, 2005 surgery.

20. The applicable standard of care in all cases which involve non-emergency surgery requires that the surgeon must perform a history and physical on the patient. In this case

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the bump of bone from the side of the 1st metatarsal head.

Once completed, the podiatric surgeon will create an osteotomy through the first metatarsal that will allow shifting the bone and realigning the joint. Depending on the type of osteotomy, the actual shape of the bone cut can vary. In the case of the Austin bunionectomy, the bone cut is V-shaped with the "V"sitting on its side and the tip of the "V" pointing toward the joint. When this cut is completed, the head of the metatarsal and joint is shifted toward the 2nd toe. In this way the bone and joint are repositioned in a more normal position.

Respondent does not remember examining the patient, speaking with her, reviewing her medical records, or ordering X-rays of her feet. Furthermore, there is no objective evidence or documentation that shows Respondent spoke to this patient, examined this patient, performed a history or physical or ordered X-rays or reviewed X-rays prior to performing surgery on this patient on August 10, 2005

21. Respondent did not perform the Austin/Akin bunionectomy for which patient Maria C. had signed the pre-operative consent form six days prior in Dr. Ivancich's office at her initial visit. Instead, Respondent's operative report shows that on or about August 10, 2005, he performed a distal first metatarsal osteotomy[7] to correct the patient's bunions.

22. Patient Maria C. received postoperative care from a series of other physicians. She complained of pain in her feet on almost every visit. The patient was given bunion splints, and had orthotics made in an attempt to relieve her pain.

23. Respondent's first postoperative examination on patient Maria C. occurred on March 21, 2006, approximately seven months after he performed her surgery. At that time Respondent diagnosed her as having pain, tibial neuritis,[8] and edema.[9] Respondent ordered X-rays, but there is no information in the patient's medical records of any X-ray results.

24. Patient Maria C. continued to complain of pain in both feet, with the addition of pain in the balls of both feet and toes. The patient ultimately consulted with three separate physicians about her worsening foot pain which was 10 on a scale of 1-to-10 three years after Respondent performed surgery on her bunions. Because Maria C. is employed at a barber shop where she must stand on her feet, this amount of pain means she is unable to endure her complete work shifts.

Physical examinations and X-rays of Maria C.'s feet showed this patient had a high

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[7] A bunion surgery usually performed for the surgical treatment of mild-to-moderate bunions.

[8] Inflammation of a nerve in the shin bone.

[9] Edema is swelling caused by excess fluid trapped in the body's tissues.

metatarsal angle[10] of approximately 15 to 16 degrees.

25. The standard of care in bunion surgery is to ascertain the patient's foot pathology along with the patient's age and other lifestyle factors in order to determine the appropriate surgical procedure to perform to achieve the best patient outcome. Due to Maria C.'s high metatarsal angle, the distal metatarsal osteotomy Respondent inexplicably chose to perform failed to reduce the inter metatarsal angle and thus Maria C.'s bunions quickly recurred. By disregarding the consented Austin/Akin procedure, and instead performing the single distal first metatarsal osteotomy, Respondent failed to correct the patient's major pathology.

Moreover, there is no objective medical evidence which supports the decision to do a single distal first metatarsal osteotomy. The medical records contain no X-rays or other tangible information indicating inter metatarsal angles or hallux abductus[11] angles which Respondent would have been able to review to make the proper decision for the correct surgical procedure for this patient.

26. Respondent's care of Maria C. was grossly negligent for the reasons stated below:

A. Respondent did not conduct a pre-operative history on his patient, Maria C., to enable him to review the history of her foot pain. Failure to perform a pre-operative history on this patient was especially significant because Respondent first met the patient immediately prior to performing surgery on her feet.

B. Respondent did not conduct a pre-operative physical examination on his patient, Maria C., to enable him to independently determine the correct surgical procedures for him to perform on her feet. Failure to perform a pre-operative physical examination on this patient was especially significant because Respondent first met the patient immediately

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[10] One of the factors considered in determining the appropriate surgical procedure is the metatarsal angle. Examples of criteria considered are: 1. The 1st inter- metatarsal angle (I.M. angle), the angle between the 1st and the 2nd metatarsal, 2. The Proximal Articular Set Angle (P.A.S.A.), the angle between the cartilage that articulates with the big toe relative to the 1st metatarsal and 3. The Hallux Abductus Angle, the angle between the big toe and the 1st metatarsal.

[11] The hallux is commonly known as the big or great toe. Hallux abductus means a fixed angulation of the hallux directed away from the body midline.

prior to performing surgery on her feet.

C. Respondent failed to review any existent pre-operative X-rays to enable him to independently determine the correct surgical procedures for him to perform on her feet. Failure to perform a pre-operative physical examination on this patient was especially significant because Respondent first met the patient immediately prior to performing surgery on her feet.

D. Respondent failed to order pre-operative X-rays to enable him to independently determine the correct surgical procedures for him to perform on her feet. Failure to perform a pre-operative physical examination on this patient was especially significant because Respondent first met the patient immediately prior to performing surgery on her feet.

E. Respondent failed to recognize Maria C.'s severe foot pathology. His failure to correctly identify the severity of the patient's foot pathology made it impossible for him to choose the correct surgical procedure to perform on his patient to ameliorate her foot problems.

F. Respondent failed to choose the correct surgical procedure to perform on Maria C.'s feet to achieve the best possible outcome to resolve this patient's foot problems.

Patient Abel M.

27. On or about July 22, 2006, 65-year-old Abel M., initially seen by Larry Ivancich, D.P.M. , had surgery on his right bunion. The right foot bunion surgery was performed by Dr. Ivancich. After the bunion surgery the patient was sent home wearing a special postoperative shoe.

28. On or about July 25, 2006, just three days after his right foot bunion surgery, Respondent saw Abel M. for a consultation and pre-operative consent for surgery on the patient's right Achilles tendon[12].

[12] The Achilles tendon (a tendon is a tough band of fibrous connective tissue that usually connects muscle to bone) is a tendon of the posterior leg. In humans, the tendon passes behind the ankle and is the thickest and strongest tendon in the body.

29. During Respondent's September 14, 2010, interview with Medical Board Senior Investigator Jaime Sandoval about patient Abel M., Respondent stated this patient was referred to him by Dr. Ivancich for surgical correction of the patient's right heel. Respondent further stated that both Dr. Ivancich, as well as the office manager, told him to do the surgery. In particular, Respondent said that Dr. Ivancich stated to Respondent in his conversation with him that if Respondent failed to complete the surgery Dr. Ivancich would not be happy with the situation.

30. On or about July 25, 2006, during his initial consultation with patient Abel M., Respondent examined the patient's right lower foot. However, Respondent's notes indicate no objective information with regard to the Achilles tendon other than Respondent noted it was "short."

31. Respondent's documented diagnostic impressions from his initial evaluation of patient Able M. were as follows: Pain; Achilles tendonitis[13]; bony prominence right posterior heel; and "short" Achilles tendon.

However, Respondent's documentation fails to note any objective measurements of the patient's right heel, range of motion, nor any other method utilized by Respondent to independently confirm that the patient's right Achilles tendon was short, or indeed, how short it was when compared to standard measurements of other Achilles tendons.

Respondent further documented that during his musculoskeletal examination of Abel M. he noted the patient had a painful Achilles tendon right posterior heel with painful bony prominence and redness in the right posterior aspect of the heel.

32. The applicable standard of care in all cases which involve non-emergency surgery requires that the surgeon must perform a complete history and physical on the patient.

During Respondent's September 14, 2010, interview with Medical Board Senior Investigator Jaime Sandoval about patient Abel M., Respondent stated Dr. Ivancich should have taken a history and physical for the original surgery which occurred July 28, 2006. Respondent stated he should have reviewed the medical records of the history and physical he assumed Dr.

[13] Achilles tendonitis is a condition of irritation and inflammation of the large tendon in the back of the ankle.

Ivancich took for the July 28, 2006 surgery. However, Respondent had no records which confirmed that he had indeed reviewed any history or physical taken by Dr. Ivancich.

Moreover, Respondent did not have any medical records of completing his own complete history and physical on patient Abel M. other than the examination of the patient's right lower foot referred to above in paragraphs 28, 30, and 31. There is no documentation that Respondent ever performed a review of systems on this patient.

Respondent's consultation notes for his examination of Abel M. on July 25, 2006, fail to document any patient complaints of right heel pain and irritation preceding to the bunion surgery he had undergone three (3) days prior to his examination by Respondent.

33. The applicable standard of care with regard to a complete pre-surgical consent is that prior to surgery the physician must fully inform the patient about the surgical procedure to be performed. The explanation should include a discussion of possible complications as well as other alternative treatment plans. The surgical consent should also include simple diagrams of the procedure that can be easily understood by the patient.

During this initial consultation with Respondent, patient Abel M. signed a surgical consent. This surgical consent shows the patient initialed the informed consent and agreed to Respondent performing a surgery listed as "Achilles tendon lengthening of the right foot to relieve tight and painful tendon."

This surgical consent from the patient's initial consultation with Respondent did not indicate any notation of markings on the posterior aspect of the calcaneous,[14] nor is there any mention of an exostectomy[15] of the posterior aspect of the patient's heel. Neither the patient's schematic diagrams depicted in the patient's medical records, nor the consent form the patient signed, indicate that Respondent intended to remove bone from the patient's right heel.

There are no medical records which show a consent form from the surgical center

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[14] The calcaneous, also commonly known as the heel bone, is one of the bones of the foot which constitutes the heel.

[15] An exostectomy is the process of removing bony bumps on the bones.

where Respondent performed the patient's surgery. Thus, there is no objective evidence which documents this patient was ever informed Respondent intended to remove portions of the patient's heel bone.

34. The applicable standard of care in all cases which involve non-emergency surgery requires that the surgeon attempt conservative treatment of the condition prior to surgical intervention.

Here, the patient's medical records document that Abel M. began to complain of pain and irritation of his right heel only three days after his bunion surgery. Nonetheless, Abel M.'s medical records show Respondent failed to suggest or prescribe any of the following conservative, non-surgical treatments prior to surgical intervention: Appropriate heel and toe padding of the patient's postoperative shoe; Night splints; Non-steroidal anti inflammatory medications; and Physical therapy.

Nor do the patient's medical records document any previous conservative care either suggested or rendered by any physician for the patient's fresh complaint of pain in his right heel immediately following surgery on the same foot. The patient's fresh complaint of right heel pain appears to have been of a type which would have responded successfully to any or all of the non-surgical treatment options listed above.

35. On or about July 28, 2006, only six days after Dr. Ivancich performed surgery on his right foot bunion, Abel M. underwent additional, non-emergency surgery performed by Respondent on his patient's right heel. Respondent's operative report documented that he performed an Achilles tendon lengthening of the right ankle, and an excision of bony prominence retro calcaneal on patient Abel M.

It is not the standard of care to operate on a patient twice in a six-day period. To do so puts the patient at great risk from complications including reaction to anesthesia, an increased risk of infection, and a greatly increased risk of pain.

If the surgery Respondent performed was truly necessary it should have been noted by Dr. Ivancich, and performed by him during the July 25, 2006, surgery on the patient's bunion.

34. On or about August 1, 2006, Respondent saw patient Abel M. for his postoperative visit. Respondent documented during his musculoskeletal examination of Abel M. that he found the patient's right heel now had good range of motion.

35. On or about August 15, 2006, Respondent saw patient Abel M. again. Respondent noted in the "treatment rendered" potion of his records that the patient "pulled the first metatarsal pin," i.e., the patient removed one of the pins Dr. Ivancich inserted during the bunion surgery he performed on the patient on July 22, 2006.

However, fourteen days later, according to Dr. Ivancich's notes of the patient's August 29, 2006 postoperative visit, the pins in the patient's foot were intact. In fact, Abel M. purposely went to Dr. Ivancich on August 29, 2006, to have Dr. Ivancich remove the two (2) pins Dr. Ivancich inserted during the patient's bunion surgery.

36. On or about September 5, 2006, Respondent saw the patient again for postoperative care. Respondent's notes under the musculoskeletal section of his report details various measurements of the patient's range of motion in his right foot. Respondent also noted an injection of some substance into the right posterior aspect of the patient's ankle in the area of the scar from the surgery Respondent performed.

37. On or about September 26, 2006, Respondent saw the patient again for postoperative care, and diagnosed him with neuritis.[16] Respondent scheduled Abel M. for surgery, and the patient signed a consent for same but there are no operative reports or other medical records which indicate Respondent performed any surgery on this patient other than that performed on or about July 28, 2006.

38. On or about November 7, 2006, Respondent treated patient Abel M. with an injection of lidocaine[17] and two different forms of cortisone[18] into his sural[19] nerve.

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[16] Neuritis is defined as inflammation of a nerve or group of nerves, characterized by pain, loss of reflexes, and atrophy of the affected muscles.

[17] Lidocaine is an anesthetic typically used to numb or treat pain in medical procedures in topical or injected form.

[18] Cortisone is a steroid hormone used to treat a variety of ailments. Cortisone suppresses the immune system, thus reducing inflammation and attendant pain and swelling at the site of an (continued...)

39. Respondent's care of Abel M. was grossly negligent for the reasons stated below:

A. Respondent performed unnecessary surgery on patient Abel M. without any documentation of conservative care rendered to the patient prior to the surgery. The patient presented to Respondent with a postoperative complaint arising from irritation from the special shoe he was told to wear after bunion surgery. Respondent's main criteria for performing unnecessary surgery on Abel M. is that he was told to do so by both Dr. Ivancich and the office manager.

B. Respondent failed to perform a complete history and physical on Abel M. prior to performing foot surgery on this patient. Respondent's medical records of his initial and only consultation with Abel M. do not show evidence of:

Patient complaint of right heel pain prior to the bunion surgery performed on his foot three days earlier;

No prior treatment to the patient's right heel;

No documentation of an examination of the patient's range of motion by Respondent;

No X-rays of the right foot and heel reviewed or ordered and reviewed by Respondent;

No review of systems;

No medical history;

No documentation of current medications used by the patient, and

No family medical history.

C. Respondent failed to fully inform the patient prior to the surgery about the surgical procedures he planned to perform. The medical records do not show that Respondent ever explained to Abel M. that Respondent would be removing a potion of the patient's right heel bone.

D. Respondent failed to obtain a complete informed consent from the patient. As

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injury. [19] Sural refers to a nerve which runs up the calf of the leg.

previously explained. Respondent failed to inform Abel M. that he intended to remove a portion of the patient's right heel bone. Without a complete explanation of all of the surgical procedures Respondent planned to perform, Abel M.'s signature on the consent was meaningless and a nullity, as the patient was not informed with regard to a most important part of his upcoming surgery. Thus, the patient was unable to meaningfully assess the risks and benefits and make an informed decision about whether he did wish to undergo a surgery.

E. The standard of care in the podiatric community is not to perform additional, non-emergency, unnecessary surgery three days after a prior surgery. There was no documented medical necessity to return this patient to surgery for these procedures a mere three (3) days following the patient's bunion surgery.

SECOND CAUSE FOR DISCIPLINE

(REPEATED NEGLIGENT ACTS)

(Bus. & Prof. Code, § 2234, subd. (c))

40. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that Respondent committed repeated negligent acts in his care of patients, Maria C. and Abel M. as listed above. The circumstances are as follows:

41. The facts and circumstances in paragraphs 13 through 39 are incorporated by reference as if set forth in full herein.

42. Listed below are the repeated negligent acts and omissions in the records of patients Maria C. and Abel M.:

A. Respondent did not conduct a complete pre-operative history and physical examination in the taking of the history of these patients;

B. Respondent did not adequately document a complete history and physical examination of these patients;

C. Respondent failed to recognize Maria C.'s severe foot pathology. His failure to correctly identify the severity of the patient's foot pathology made it impossible for him

to choose the correct surgical procedure to perform on his patient to ameliorate her foot problems;

D. Respondent failed to choose the correct surgical procedure to perform on Maria C.'s feet to achieve the best possible outcome to resolve this patient's foot problems;

E. Respondent performed unnecessary surgery on patient Abel M. without any documentation of conservative care rendered to the patient prior to the surgery;

F. Respondent failed to fully inform Abel M. prior to the surgery about the surgical procedures he planned to perform;

G. Respondent failed to obtain a complete informed consent from Abel M. prior to the patient's surgery; and

H. Respondent performed unnecessary, non-emergency surgery on Abel M. three days after the patient underwent surgery, thereby exposing his patient to needless risk and pain.

THIRD CAUSE FOR DISCIPLINE

(FAILURE TO MAINTAIN ADEQUATE AND ACCURATE RECORDS)

(Bus. & Prof. Code, § 2266)

43. Respondent is subject to disciplinary action under section 2266 of the Code in that Respondent failed to maintain adequate and accurate records in his care of patients Maria C. and Abel M. The circumstances are as follows:

44. The facts and circumstances in paragraphs 13 through 39 are incorporated by reference as if set forth in full herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Podiatric Medicine issue a decision:

1. Revoking or suspending Podiatric License Number E 4361, issued to Ramyar Moussavi, D.P.M.

2. Ordering him to pay the Board of Podiatric Medicine the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section

2497.5;

3. If placed on probation, ordering him to pay to the Board of Podiatric Medicine the costs of probation monitoring;

4. Taking such other and further action as deemed necessary and proper.

DATED: May 4, 2011

JAMES RATHLESBERGER
Executive Officer
Board of Podiatric Medicine
Department of Consumer Affairs
State of California

Complainant

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